

Clinical Image

Placenta Previa Percreta: An Essential Diagnosis not to Miss!

Hurni Y^{1*}, Lipp von Wattenwyl B¹, Bonollo M¹, Ferrero L¹, Wytttenbach R² and Canonica C¹

¹Department of Obstetric and Gynecology, Ospedale Regionale Bellinzona e Valli, Switzerland

²Department of Radiology, Ospedale Regionale Bellinzona e Valli, Switzerland

*Corresponding author: Hurni Y, Department of Obstetrics and Gynecology, Ospedale Regionale Bellinzona e Valli - Bellinzona, Switzerland

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A 34-year-old woman, II-gravida I-para, presents at 12 weeks of gestation for painless vaginal bleeding with a transvaginal ultrasound showing a low-lying placenta. The patient had a history of a prior caesarean section two years prior due to breech presentation. The combination of low-lying placenta and a prior caesarean section remarkably increases the risk of an abnormally invasive placenta. A high index of suspicion is therefore required when evaluating such a pregnant woman. Careful examination revealed characteristic findings, suggesting placenta praevia percreta with bladder invasion on both greyscale and colour Doppler ultrasound (Figure 1) [1,2]. The diagnosis was supported by additional features observed on MRI (Figure 2) [2,3]. Placenta praevia percreta is among the greatest diagnostic and treatment challenges in current obstetrics. Its incidence is rising in association with the rising rate of caesarean sections. A multidisciplinary team approach is essential in managing this potentially catastrophic condition. But first, do not miss the diagnosis!

References

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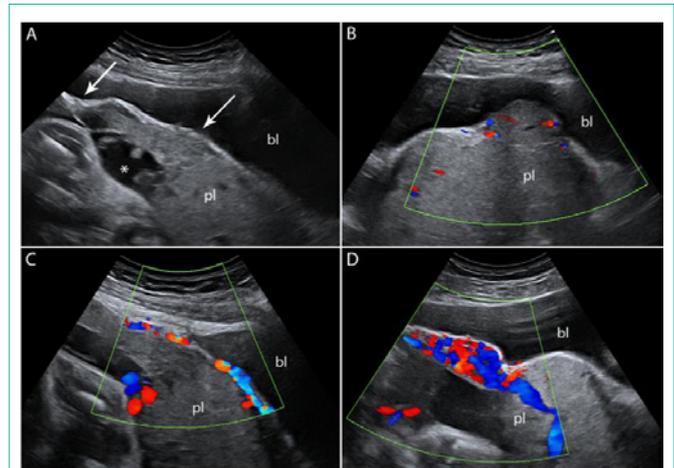


Figure 1: Transabdominal ultrasound at 30 weeks of gestation, A: Loss of hypoechoic plane in myometrium underneath the placental bed, reduced myometrial thickness, interruption of the bladder wall (arrows), abnormally large and irregular placental lacunae (asterisk), and B: Placental tissue bulging into the bladder. Colour Doppler reveals, C: Bridging vessels extending from placenta into bladder wall and (D) uterovesical hypervascularity. *pl* = placenta; *bl* = bladder.

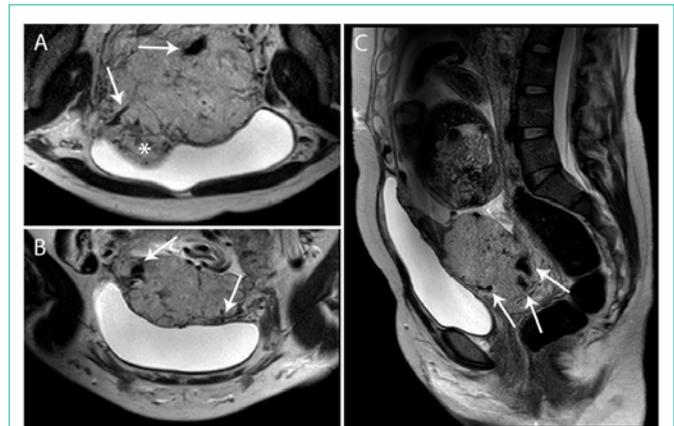


Figure 2: A, B: Axial and C: Sagittal T2-weighted magnetic resonance images obtained at 30 weeks of gestation, showing a placenta with heterogeneous signal, lumpy contour, rounded edges, dark intraplacental bands (arrows A, B and C), hypointense line disruption at the myometrial interface, and placental tissue bulging into the bladder (asterisk, A).